NORTH CAROLINA MEDICAL BOARD

Adverse Actions Report March-April 2024

The digital edition of the *Forum* presents a two-month report of recent adverse actions. This report does not include non-adverse action such as reentry agreements or relief of consent order obligations. To view all public actions, visit www.ncmedboard.org/BoardActions.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
DHAWAN, Surinder, MD (009701318) Cary, NC	03/08/2024	In October 2023, MD entered into a Consent Order with the Board in which he agreed to schedule a comprehensive examination at the first available appointment date within three months of the 2023 Consent Order. In January 2024, MD notified Board staff that he would not be scheduling a comprehensive exam. MD admitted at the hearing that he had not scheduled the examination as required by the 2023 Consent Order. The Board found that MD had violated the provisions of his Consent Order.	Summary Suspension of 01/26/2024 upheld
REVOCATIONS			
HARGRAVE, Ronald Paul, MD (000031028) Mt Pleasant, SC	04/25/2024	July 2019 felony controlled substance convictions	Medical license revoked
SUSPENSIONS			
KUMAR, Pankaj, MD (201401466) Winston-Salem, NC	03/06/2024	Following a DWI arrest in 2021, the Board required MD to submit to an examination by the North Carolina Professionals Health Program. MD completed the examination and NCPHP did not believe he had an undiagnosed or untreated Substance Abuse Disorder. However, NCPHP recommended MD complete an outpatient	License indefinitely suspended retroactively, effective June 27, 2023

		neuropsychological examination and attend therapy sessions. In May 2023, while at work and feeling ill, MD was escorted to the emergency room for a physical and psychological assessment. His blood alcohol concentration was .217. MD was transferred to a behavioral health center for treatment of severe depression. He entered in-patient treatment and successfully completed a 61-day treatment program for Alcohol Use Disorder. MD subsequently signed a five-year monitoring contract with NCPHP and is compliant with his monitoring contract and abstaining from alcohol use.	
LIMITATIONS/CONDITIONS			
GILL, Lowell Harley, MD (000016865) Charlotte, NC	03/01/2024	In May 2022, MD's clinical staff privileges were restricted due to concerns about possible lack of physical stamina to perform certain surgical cases, cognitive function, and medical decision-making. The Board referred MD for neuropsychological and neurocognitive testing. The examiner felt that MD was experiencing mild cognitive impairment and that he should not perform surgery. The examiner did, however, opine that MD may practice medicine, non-surgery, with appropriate monitoring and supervision by a physician peer. MD has not practiced medicine since August 2022, desiring to cooperate throughout this process.	Consent Order; MD shall not perform surgery, surgical procedures, nor assist in any surgery or surgical procedure

GOUDARZI, Hormoze Abbass, MD (000026073) Wilmington, NC	04/23/2024	The Board received a complaint from a physician who had concerns about the care provided by MD for two patients. Both patients had been referred to the physician for treatment of breast cancer, after previously being evaluated by MD. In the case of Patient A, the Board's reviewing expert questioned MD's choice to perform an excisional biopsy under general anesthesia instead of an in-office core needle biopsy. Also, the reviewing expert criticized MD's delay in the management of Patient's breast cancer to perform a colonoscopy, and MD's surgical approach. The reviewing expert also found that MD's care of Patient B failed to conform to the standards of acceptable and prevailing medical practice in NC. Specifically, the expert criticized MD's decision to delay further assessment of Patient B's potential breast cancer. The reviewing expert stated that MD did not perform the standard of care for the finding of a breast mass by mammogram that is suspicious for cancer.	Consent Order; MD shall not provide cancer treatment to any cancer patient
REPRIMANDS			
FRANK, Madeline Terese, PA-C (001012715) Syracuse, NY	04/17/2024	PA committed a violation of the Health Insurance Portability and Accountability Act (HIPAA) when she revealed identifiable facts, data, or information without prior consent of two separate patients. She took and	Reprimand

		posted a video on her personal Snapchat account, which included footage of the emergency department and graphic images within a patient's room. The posted video also contained an image of a second patient's electronic medical record. The New York Medical Board censured and reprimanded her for an "unintentional HIPPA violation."	
ROGATNICK, Lewis Andrew, MD (202301110) Clayton, NC	04/16/2024	The Board received a complaint from a pharmacist that MD has been calling in prescriptions, including controlled substances, for close family members or those with whom he has a close personal relationship. In doing so, MD violated the rule which prohibits prescribing controlled substances for the use of the physician's immediate family. Such acts constitute unprofessional conduct.	Reprimand
DENIALS OF LICENSE/APPROVAL			
KONESWARAN, Suresh Aravinth, MD (201400260) Greensboro, NC	03/04/2024	In January 2022 MD's license was indefinitely suspended by the Board based on allegations that he made numerous inappropriate phone calls of a personal nature to a female patient and that during telehealth visits with two additional female patients MD made inappropriate comments and requested the patients expose their breasts. During the Board's investigation it discovered that in 2012, MD's then-out-of-state	Denial of Licensure

		employer received complaints regarding inappropriate contact with patients. In June 2023, MD applied for reinstatement of his NC medical license and disclosed that in 2009 during his fellowship, a complaint was made concerning his examination of a female. MD's failure to disclose previous complaints on his initial license application constitutes making false statements or representations to the Board, or willfully concealing from the Board material information in connection with an application for a license.	
SURRENDERS			
CARR, Stephen C, PA-C (001004726) Hubert, NC	03/27/2024	After an appointment, PA messaged a patient through her personal Facebook account commenting on her physical attractiveness. Although Patient did not respond, PA continued his to try to reach her for almost two weeks using her patient portal, Facebook, and Instagram. After 12 days of constant attempted contact, Patient filed a police report and reported PA's behavior to his employer. Following an examination, NCPHP recommended that PA submit to a comprehensive behavioral evaluation. NCPHP did not support PA's return to practice until the comprehensive behavioral evaluation was completed and the results were reviewed by NCPHP. The	Surrender of NC medical license; Reprimand

		Board issued an order requiring PA to submit to a professional examination by a Comprehensive examination center. PA informed the Board that he would not comply.	
PITTMAN, Tyler Cade, DO (201902592) Elizabeth City, NC	04/24/2024		Voluntary surrender of medical license
PUBLIC LETTERS OF CONCERN			
CAMPBELL, Dennis Michael, MD (201400761) Asheville, NC	03/21/2024	The Board is concerned about MD's care of a 63-year-old female on whom he performed surgery to remove damaged C4-C7 vertebrae, relieve the pressure on her spinal cord and join the C4-C7 vertebrae to stabilize her neck. Over the next six months Patient complained that her left arm function remained reduced, despite continued physical therapy. The Board's reviewing expert opined that at Patient's first post-operative appointment, the office x-rays, coupled with the new neurological deficit, should have been an indication that the DTrax spacers at C4/5 were malpositioned. Although MD ordered more detailed studies to better assess potential issues, he did not offer immediate reoperation after reviewing the CT myelogram and noted that “the right C4-5 facet fusion device was a little bit anterior in the left C5-6 facet fusion devices posteriorly displaced.”	Public Letter of Concern
CERAME, Mario A., MD (000032479) Laurinburg , NC	04/22/2024	The Board is concerned about MD's care of a 50-year-old female on whom MD performed a guided	Public Letter of Concern

		aspiration for cytology with no complications. The aspiration cytology results were suspicious for carcinoma. After reviewing the results with the patient, MD mistakenly documented and later performed a left thyroid lobectomy, rather than a right thyroid lobectomy. MD contacted Patient and informed her of the error and recommended that she undergo a complete thyroidectomy. Pathology ultimately showed that the nodule was benign and not cancerous as initially indicated. Due to MD's error, Patient had to undergo a second surgery and the removal of her entire thyroid gland, requiring lifelong thyroid hormone replacement.	
GAGE, Mark Joseph, MD (201700871) Durham, NC	03/27/2024	The Board is concerned that MD's attempted repair of a patient's scapular spine fracture following reverse shoulder arthroplasty may have departed from the prevailing medical practice. Specifically, he applied two plates to address the scapular neck fracture but did not repair the scapular spine fracture by plating at the fracture site. The Board's reviewing surgeon felt a reduction and internal fixation of the scapular spine fracture was the preferred surgical approach.	Public Letter of Concern
GARRETT-ALBAUGH, Sheli Ruth, DO (201100707) Morehead City, NC	04/16/2024	The Board is concerned that DO's care of a patient fell below the standard of care. Specifically, DO failed to perform a physical	Public Letter of Concern

		examination of a 29-year-old female prior to diagnosing her with an ectopic pregnancy and failed to follow Patient's hCG levels long enough to diagnose an ectopic pregnancy before treatment with methotrexate.	
KATIBAH, William George, III, MD (000031155) Charlotte, NC	03/13/2024	During the Board's investigation of a complaint, it also learned that MD treated himself and some of his immediate family members. In doing so, MD violated the rule that prohibits prescribing controlled substances for use by the physician's immediate family. Such acts constitute unprofessional conduct.	Public Letter of Concern; MD to complete CME on medical record documentation and treating and prescribing to family, self, and close relationships.
KULWA, Ema Wakuru, MD (201500664) Greensboro, NC	04/01/2024	The Board is concerned that MD performed a laparoscopic total vaginal hysterectomy, bilateral salpingectomy, and cystoscopy on a 53-year-old female with a history of diabetes and uterine fibroids. During the surgery, a urology specialist was contacted for assistance to repair a bladder injury. After MD completed this surgery and while Patient was still hospitalized, a pathology report identified colonic tissue in the specimens submitted, which indicated a bowel injury had occurred during the surgery. Patient then required additional surgery which included a colostomy. The Board's independent medical expert felt MD's diagnosis and records relating to Patient	Public Letter of Concern; MD shall complete CME regarding management of difficult laparoscopic hysterectomies

		were acceptable under the circumstances. While this expert recognizes that Patient's surgical complications do fall within the spectrum of common possible complications of the procedure performed, the expert also opined that additional actions could have been initiated during the surgical procedure to potentially decrease risks andincrease the chances to maximize intraoperative identification of the bowel injury at the time of the surgery.	
MAHONEY, Mark Thomas, DO (202400912) Mount Airy, NC	04/22/2024	The Board is concerned that DO was reprimanded by the Virginia Board in 2020 for substandard prescribing, including prescribing controlled substances to his employees without first performing adequate physical examinations, ordering diagnostic imaging to determine the cause of pain, and without first attempting non-opioid treatment modalities before initiating opioid therapy. In addition, the Virigina Board found that with regard to six patients, DO failed to practice appropriate pharmacovigilance and monitor patients adequately. At times, he did not perform pill counts or conduct urine drug screens, nor did he always query the Prescription Monitoring Program to guard against possible concurrent prescribing by providers. DO also failed to document his	License issued with Public Letter of Concern

		rationale for continuing some patients on opioid therapy or measure progress in obtaining pain relief. In some instances, he failed to refer patients to pain management specialists for management of their chronic pain, prescribed early refills of narcotic pain medications, and concomitantly prescribed opioids with benzodiazepines, contrary to sound medical judgment. In some cases, DO prescribed weight loss medication without documenting patients' weight or diagnoses, establishing a target weight and exercise plan, or scheduling follow up after initial prescribing. DO renewed weight loss medication without seeing the patients or monitoring their weight. DO completed CME on opioid prescribing and professional boundaries in medicine and complied with the Virigina Board Order.	
MARKY, Andrew Hall, MD (201900191) Charlotte, NC	04/03/2024	The Board is concerned by the unintentional retention of a Caspar pin during surgery on a 59-year-old male. MD performed neck surgery on Patient to remove a damaged disc and relieve pressure on his spinal cord. During the surgery, MD placed devices to separate the vertebrae allowing him to insert the spinal hardware. The surgery was routine, without obvious	Public Letter of Concern

		complications and Patient was discharged home the next day. At Patient's two-week follow-up, postoperative x-rays showed a retained Caspar pin at the C7 vertebrae. A brief surgery was performed that same day that removed the Caspar pin without further incident. Patient did not have any long-term effects because of the retained Caspar pin or secondary surgery. MD immediately took responsibility and have taken steps to ensure this does not reoccur.	
MCKINLEY, Christopher Mark, PA (001008986) Leland, NC	03/06/2024	The Board is concerned that PA's care of three patients may have failed to conform to acceoted standards of care. Following a complaint about the administration of testosterone at a practice where PA is employed, the Board had PA's care of three patients reviewed by an independent medical expert. During the Board's investigation, it was discovered that PA provided bioidentical hormone replacement therapy through testosterone pellet insertion to his supervising physician and a member of his immediate family. The Board's reviewing expert expressed concern that PA relied upon dosing calculations for testosterone pellet insertion. Additionally, the reviewer had concerns about PA's documentation and failure to make appropriate	Public Letter of Concern; PA will complete eight hours continuing medical education on the subject of Hormone Replacement Therapy

		adjustments in dosage.	
MOORE, Carlton Reid, MD (200701526) Chapel Hill, NC	04/23/2024	The Board is concerned that from May 2021 to November 2023, MD prescribed controlled substances multiple times to immediate family members. MD failed to keep a medical record or otherwise document prescriptions. MD has violated the rule which prohibits prescribing controlled substances for the use of the physician's immediate family. Such acts constitute unprofessional conduct.	Public Letter of Concern
NGUYEN, Trung Nam, DO (201802339) Tyler, TX	04/09/2024	The Board is concerned about DO's care of a 53-year-old male in an emergency department ten hours after he sustained a high-pressure injection injury to his left index finger. Blood work and an x-ray of Patient's hand were done. Patient was discharged that day with oral antibiotics, analgesics and antihypertensives with instructions to elevate the injured hand. Patient returned to an emergency department six days later with finger necrosis and was admitted to a hospital for surgery to try and repair his left index finger. The Board's independent medical expert thought that DO should have considered obtaining a surgical consultation when he first treated Patient. The Board is also concerned that in March 2023 DO entered into an Agreed Order with the Kentucky Board based on a concern related to DO's	Public Letter of Concern; DO agrees to complete continuing medical education

		prescribing of the drug phentermine for weight loss. The Agreed Order restricted DO from prescribing any controlled substances until that restriction was lifted by the Kentucky Board. The Order specifically provided for a competency assessment. DO completed remediation in December 2023 and the Kentucky Board's Agreed Order was terminated effective April 1, 2024.	
ORTIZ, Diana Isabel, MD (201902620) East Norriton, PA	03/05/2024	The Board had MD's care of a 51-year-old male reviewed by an independent medical expert. The patient presented to the emergency department with a 2-day history of abdominal pain associated with nausea, vomiting, and diarrhea. The reviewing expert found that MD's care of Patient may have fallen below the standard of care. Specifically, abnormal areas of small bowel were concerning for obstruction, especially when they had not resolved after a week of observation. The reviewing expert criticized the delay in surgical intervention and opined that surgery prior to the fulminant sepsis may have resulted in a definitive diagnosis, treatment, and survival.	Public Letter of Concern; MD will complete four hours CME concerning partial bowel obstruction indications for surgery
SMITH, John Thomas, MD (202400717) Monroe, NC	04/03/2024	The Board is concerned regarding the events which led to MD and the Minnesota Board entering into an Agreement for Corrective Action in 2021, based upon the evaluation	License issued with Public Letter of Concern

		of his care of a patient and her infant. MD was ordered to successfully complete CME courses regarding gestational diabetes and shoulder dystocia; and submit a paper documenting what he learned in the CME and how he incorporated this knowledge into practice. After reviewing documentation, the Minesota Board concluded the terms of MD's Agreement had been satisfied.	
SMITH, Timothy Ted, DO (009401340)	03/20/2024	The Board is concerned that DO's care of a 42-year-old male who presented to the emergency department with back, hip, abdominal pain and hand weakness may have fallen below the standard of care. DO did not perform a detailed neurologic examination to include upper extremity strength testing, lower extremity strength testing, or assessment of gait. DO failed to document the degree of dysfunction of Patient's hand weakness or any associated symptoms or involvement of other parts of the body. DO did not document any exacerbating or alleviating factors, nor document if the symptoms involved the entire hand, or if both hands were affected to an equal degree. A week after DO saw Patient in the ED, he was unable to walk and was diagnosed with severe spinal cord compression/incomplete	Public Letter of Concern

		quadriplegia.	
THOMAS, James Benjamin, Jr., DO (202400826) Wilmington, NC	04/12/2024	The Board is concerned that DO failed to disclose six malpractice cases in the Malpractice Data section of his license application. In addition, DO failed to disclose a 2008 Alabama Medical Board investigation. MD's failure to disclose previous malpractice cases and investigations on his initial license application constitutes making false statements or representations to the Board, or willfully concealing from the Board material information in connection with an application for a license.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			